VI. OTHER CLAIMS PROCESSING REQUIREMENTS

A. Automated Eligibility, Deductible, and Claims History Data Requirements

1. File Function and Content

The contractor must maintain, on the automated data system, all the necessary data elements to ensure the ability to reproduce both Health Care Service Records (HCSRs) and Explanations of Benefits (EOBs), if necessary, and to operate an effective duplicate detection system. The automated system must be able to accurately identify each beneficiary and his or her history. Unless the beneficiary is enrolled in TRICARE Prime, *the system* must correctly apply deductibles and reflect deductible status and deductible history for the current year and two (2) prior years for both individuals and families. When the beneficiary is enrolled in TRICARE Prime, the system must be capable of recording the enrollment fees, copayments and/or any deductible/cost-share variations and retain the flexibility to handle the enrollment *to* and disenrollment from TRICARE Prime. *When different members of a family are enrolled in different regions, the family is responsible for tracking enrollment year catastrophic cap accumulations for all family members and for providing evidence that the catastrophic cap has been met when a claim is filed (see Policy Manual, Chapter 12, Section 2.2 and OPM Part Three, Chapter 4, Section II.J.).* Regardless of enrollment status, the system must be capable of calculating and displaying a cumulative total of the amounts (enrollment fees, deductibles, cost-shares and copayments) accumulated *by the entire family* toward the catastrophic loss protection threshold (catastrophic cap) (see Policy Manual, Chapter 12, Section 2.2). On January 1st of each year, the contractor *shall* carry not less than fifteen (15) months of claim history and *shall* add data each month throughout the year for a total of not less than twenty-seven (27) months of claim history on file on December 31st.

2. Special File Requirements

The automated system must also provide for records of other health insurance, or a system of flagging, which will ensure proper identification and review of double coverage claims and accurate application of other health insurance payments. In addition, flags or other records must provide screening for:

a. Authorization/preauthorization of residential treatment and Program for Persons with Disabilities.

b. Utilization Controls

c. Psychiatric/psychological services consistent with the Policy Manual.

3. Audit Trail and File Integrity

The contractor *shall* ensure *that* the history file accurately reflects all transactions pertaining to care received, cost-shares, deductible, copayments, and adjustments. The *contractor shall maintain the* integrity of the audit trail and *protect* the confidentiality and integrity of the files.

B. Allowable Charge Application

(Refer to the OPM Part Two, Chapter 4, Reimbursement.)

1. General

The TRICARE allowable charge for a service or supply shall be the lowest of the billed charge, the prevailing charge, or the Medicare Economic Index (MEI) adjusted prevailing charge (known as the maximum allowable prevailing charge). The profiled amount (the prevailing charge or the maximum allowable prevailing charge, whichever is lower) to be used is based upon the date of service. The prevailing charges and the maximum allowable prevailing charges shall be determined according to the instructions in the OPM Part Two, Chapter 4. Regardless of the profiled amount, no more than the billed amount may ever be allowed.

NOTE:

If, under a program approved by the Director, TMA, a provider has agreed to discount his or her normal billed charges below the profiled amounts, the amount allowed may not be more than the negotiated or discounted charges. When calculating the TRICARE allowable charge, use the discounted charge in place of the provider's actual billed charge unless the discounted amount is above the billed charge. When the discounted amount is above the billed charge, the actual billed charge shall be used.

2. Reserved

3. Reserved

4. Reserved

5. Prevention of Gross Dollar Errors

a. Parameters Consistent with Private Business

The contractor shall establish procedures for the review and authorization of payment for all claims exceeding a predetermined dollar amount. These authorization schedules shall be consistent with the contractor's private business standards.

b. Comparison of Billed Charge with Allowed Amount

For professional services and all other services reimbursed based on the prevailing charge methodology (except for care rendered by managed care support network providers), contractors shall perform a reasonability check comparing the billed charge with the allowed amount. If the billed charge is fifty percent (50%) or less or two hundred percent (200%) or more than the allowed amount, the *contractor* shall pend *the claim* and review *it* for accuracy of the procedure code and number of services. If the billed charge falls within the 50% to 200% range, the *contractor* shall pay *the claim* at the allowed level. (Contractors desiring to apply more stringent controls may do so.)

EXAMPLE 1:

$65.00 Billed
$30.00 Allowed
$15.00 50% of allowed
$60.00 200% of allowed
Since the $65.00 billed does not fall within the range, the claim would be pended for review

EXAMPLE 2:

$40.00 Billed
$30.00 Allowed
$15.00 50% of allowed
$60.00 200% of allowed
The billed amount falls within the range; thus, the allowed amount of $30.00 could be paid without review.

6. ***Reserved***

a. ***Reserved***

(1) ***Reserved***

(2) ***Reserved***

(3) ***Reserved***

(a) ***Reserved***

(b) ***Reserved***

b. ***Reserved***

c. ***Reserved***

d. ***Reserved***

(1) ***Reserved***

(2) ***Reserved***

e. ***Reserved***

f. ***Reserved***

g. ***Reserved***

h. ***Reserved***

(1) ***Reserved***

(2) Reserved

i. Reserved

(1) Reserved

(2) Reserved

(3) Reserved

(4) Reserved

(5) Reserved

7. Rebundling of Procedures - Claims Subject to Claimcheck

TRICARE does not allow a separate payment for procedures that are component parts of a more comprehensive group of services performed at the same time. When component parts are billed separately, i.e., unbundled or fragmented, the allowable amount for the more comprehensive procedure is to be used in determining reimbursement and the unbundled procedures disallowed as being covered by the amount allowed for the comprehensive procedure. Refer to the Policy Manual, Chapter 13, Section 1.4 and Chapter 11, Section 14.1.

a. Medical Review of Rebundled Procedures

Procedures are to be subjected to the rebundling edits prior to determining if medical review is necessary. The requirement for medical review is to be determined based on the rebundled, comprehensive procedure, not a fragmented procedure. *Rebundling rules do not allow reimbursement of fragmented procedures*.

b. Allowable Charge Reviews

Beneficiaries and participating providers have the right to request a review of the amount allowed for rebundled claims. The disallowance of unbundled procedures is an allowable charge issue and is not appealable. The procedures in the OPM Part Two, Chapter 8, apply for these reviews the same as for any other type of allowable charge reduction.

c. Postimplementation Provider Notification

Contractors shall establish procedures for detecting providers who submit fragmented claims to monitor billing practices and focus on providers with egregious patterns. Reports are to be produced at least quarterly which identify these providers and the fragmented codes billed for educational contacts by professional relations staff. These contacts are to be documented. Contractors are to advise providers that unbundled billings are in violation of acceptable billing practices and repeated occurrences may be considered potential fraud or program abuse in accordance with the 32 CFR 199.9. Contractors shall refer noncompliant providers to their program integrity unit no later than the third occurrence following the initial educational contact and issue written notice that exclusion from the program can result if unbundled billings continue.

d. Procedure Code Accuracy

To assist procedure coding accuracy, consistency, and reliability at the claim entry level for the procedure code rebundling edits, contractors shall install an automated encoding capability. A functional capability equivalent to that available with the GMIS software product called Autocoder is recommended.

e. HCSR Reporting Requirements

(1) Procedures bundled into another billed procedure code. When certain billed procedure codes are denied and bundled to a more appropriate code that also has been billed, the bundled line items for which no allowable amount applies are to be denied and reported on the HCSR using Denial Reason Code "GG".

EXAMPLE

Procedures A and B are billed at $100.00 each. TRICARE Claimcheck rebundles procedure A into procedure B which is a more comprehensive procedure code and reflects the more appropriate billing of procedures A and B.

Code	Billed	Status
A	$100.00	Denial Reason Code GG
B	$100.00	$100.00 (New Pricing Code F - O)

Both procedures A and B are billed on the claim. Procedure A is denied using Denial Reason Code GG.

(2) Procedures bundled into an unbilled procedure code (TRICARE Claimcheck inserted procedure code). When TRICARE Claimcheck inserts a procedure code that has not been billed on the claim and rebundles the billed procedures into that code, the following reporting requirements apply. The bundled, billed procedures are to be deleted and the TRICARE Claimcheck inserted procedure code is to be reported on the HCSR using the appropriate Pricing Code (codes F through O that are TRICARE Claimcheck-specific).

EXAMPLE

Procedures A and B are billed at $100.00 each. TRICARE Claimcheck inserts a third code to the claim, procedure C, which reflects the more appropriate billing of procedures A and B.

Code	Billed	Status
A		Deleted
B		Deleted
C	$200.00	$100.00 (New Pricing Code F - O)

Procedures A and B are deleted and procedure C (which was not actually billed on the claim but was inserted by TRICARE Claimcheck) is reported using the appropriate Pricing Code (codes F through 0).

(3) Procedures identified as mutually exclusive, incidental, or an unnecessary assistant surgeon by TRICARE Claimcheck. When TRICARE Claimcheck denies any billed procedure, that procedure is to be reported on the HCSR using Denial Reason Code GG.

f. EOB Message Requirements

(1) An appropriate EOB message is to be reported on EOBs for the disallowed component procedures, whether submitted on the same claim with the comprehensive procedure or on a separate claim:

(2) An appropriate EOB message is to be reported for comprehensive procedures for which the allowable amount is reduced due to payment of the component procedure(s) on a previous claim.

g. Quarterly Rebundling Summary Report

*Contractors shall submit r*ebundling summary reports in the format specified at *Figure 2-1-C-1* to TMA, Managed Care Support *Office* beginning with the first quarter after implementation of TRICARE Claimcheck. By the end of the month after each quarter, Contractors are to submit to TMA a report by contract area which provides the following information for the report quarter:

(1) The number of unduplicated providers (participating and nonparticipating) having billings which failed any of the rebundling edits, regardless of whether on single or multiple claims.

(2) The number of times the edits were invoked.

(3) The total billed amount for the edited procedures (both Column One and Column Two procedures).

(4) The total allowed amount for the rebundled procedures.

(5) The total dollar savings which is defined as the difference between the otherwise allowable amount (lower of prevailing or billed) for the unbundled procedures billed and the amount allowed as a result of rebundling.

8. Billing Outpatient Therapies

Outpatient rehabilitation services that require HCPCS coding are outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy service. The following providers must use HCPCS codes to bill outpatient rehabilitation services when provided to their outpatients:

- Hospitals
- Outpatient therapy providers
- Skilled nursing facilities
- Home health agencies

- Comprehensive outpatient rehabilitation agencies

C. Application of Deductible and Cost-Sharing

See the Policy Manual, Chapter 13, Section 11.1.

1. Claim Order for Applying Deductible

The outpatient deductible amounts shall be applied as the claims are processed. When claims are adjusted, the contractor shall apply the deductible based upon the date the claim was initially processed, not the date the claim was subsequently adjusted.

2. Deductible Documentation

Contractors must furnish a deductible certificate or show the status of the deductible on the EOB except on complete denials. For complete denials the contractor does not query any internal or external catastrophic cap and deductible files and is not required to send deductible information or catastrophic cap information on the denial notice. For services in fiscal years included in CDCF, obtain the amount met toward the deductible from the CDCF. When a claim is adjusted, the contractor shall query CDCF and apply deductible and cap as directed by the CDCF query response. Do not review any intervening claims processed between the initial claim and the adjustment for the purpose of adjusting deductible or cap amounts. For services in prior years, the beneficiary is responsible for attaching documentation of the deductible taken by other contractors. The contractor shall determine from their deductible record, and/or EOB from other contractors submitted by the beneficiary, the amount the contractor has to assess toward the deductible on the current claim. When a beneficiary subsequently documents an excess deductible, the claim will be adjusted by the contractor that took the excess, based on the order in which claims were processed.

3. Reserved

4. Reserved

5. Central Deductible and Catastrophic Cap File (CDCF)

a. For non-network TRICARE claims, cost-share and deductible amounts shall be applied toward the catastrophic cap as the claims are processed for each fiscal year. For TRICARE Prime and TRICARE Extra claims, all beneficiary cost-shares and deductibles specified in the contract shall be applied toward the cap, including nominal copayments for outpatient care. The amount applied toward the cap on the current claim and the family's cumulative total must be reflected on the EOB, except on complete denials. For complete denials the contractor does not query catastrophic cap and deductible files and is not required to send "cap met" information on the denial notice. For fiscal years included in the CDCF, obtain the amount of Catastrophic Loss Protection cap met, from the CDCF. For prior years the contractor is to use their internal catastrophic cap record. The beneficiary is responsible for informing the contractor through submission of EOBs of deductible and cost-shares paid in a different contractor's jurisdiction. The beneficiary must also provide the EOBs to the contractor for credit to be given for fiscal years not maintained on CDCF. The contractor must determine which services are creditable toward the catastrophic cap by reference to the Policy Manual, Chapter 13, Section 14.1. When requested by the beneficiary in writing, the current contractor shall verify the amounts paid

with the other contractor or CCS contractor, and include the total toward the catastrophic cap. For purposes of catastrophic loss protection, a TRICARE claim must be submitted along with an EOB from other health insurance for the beneficiary to receive credit for any amount paid by other health insurance, even if the OHI paid the bill in total. Once the contractor determines that the maximum individual/family liability is met for the fiscal year, cost-shares and deductibles will no longer apply, and the TRICARE-determined allowable amount shall be paid in full for all covered services and supplies under the Basic Program through the end of that fiscal year. Refer to the Policy Manual, Chapter 13, Section 14.1. If an adjustment changes whether the cap is met or not, all subsequent claims on history must be adjusted to apply or waive cost-shares. Normal double coverage rules remain in effect after the cap has been reached; the beneficiary must submit a claim to his other health insurance before submitting a claim to the contractor.

b. When coordination is required between contractors for fiscal years not included in the CDCF, the contractors will exchange family claims history files (hardcopy only) for the fiscal year in question. Each contractor is then responsible for appropriately annotating its own system to ensure that no further deductibles or cost-shares are withheld for the remainder of the fiscal year. Claims requiring adjustment will be determined by merging the family's claims history to determine the exact date on which the cap was met based on the date claims completed processing. Each contractor will then adjust all claims it adjudicated after this date and refund the over withheld cost-share or deductible.

c. For treatment of enrollment fees where the catastrophic cap has been met, see OPM Part Three, Chapter 4.

6. Adjustments and Recoupments

If the contractor is required to recoup a benefit payment any deductible amount applied to the claim to be recouped must be adjusted on the CDCF to reflect that amount as an outstanding deductible. If the contractor had a claim cycle in which an extensive number of claims did not have the deductible amount applied as a result of system or administrative errors, the contractor must proceed with recoupment action in accordance with OPM Part Two, Chapter 5. For example, if the contractor had errors involving multiple claims within the same claims processing cycle, the recoupment procedures at OPM Part Two, Chapter 5 will be followed. Any other credited deductible amount resulting from an individual claim adjustment will be offset from future claims received for the beneficiary. The government has determined that it is not cost effective to collect any outstanding deductible amounts at the close of the timely filing period.

7. Claims With Negotiated Rate Agreements

Under special programs approved by the TMA Director, where there is a negotiated (discounted) rate agreed to by the provider, the cost-share shall be based on the following:

a. For noninstitutional providers rendering outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share twenty percent (20%) for outpatient care to active duty family members, twenty-five percent (25%) for care to all others) shall be applied to, after duplicates and noncovered charges are eliminated, the lowest of the billed charge, the prevailing charge, the maximum

allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge, after duplicates and noncovered charges are eliminated.

b. For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for other than active duty family members shall be the LOWER OF EITHER:

(1) The single, specific per diem supplied by TMA (Policy Manual, Chapter 13) after the application of the agreed upon discount rate; OR,

(2) Twenty-five percent (25%) of the billed charge.

c. For institutional providers subject to the Mental Health per diem payment system (high volume hospitals and units), the cost-share for other than active duty family members shall be twenty-five percent (25%) of the hospital per diem amount **after** it has been adjusted by the discount.

d. For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for other than active duty family members shall be the LOWER OF EITHER:

(1) The fixed daily amount supplied by TMA (Policy Manual, Chapter 13) after the application of the agreed upon discount rate; OR,

(2) Twenty-five percent (25%) of the billed charge.

e. For Residential Treatment Centers, the cost-share for other than active duty family members shall be twenty-five percent (25%) of the TRICARE rate after it has been adjusted by the discount.

f. For institutions and for institutional services being reimbursed on the basis of the TRICARE-determined reasonable costs, the cost-share for other than active duty family members shall be twenty-five percent (25%) of the allowable billed charges **after** it has been adjusted by the discount.

NOTE:

For all inpatient care concerning active duty family members, the cost-share shall continue to be either the daily charge or $25 per stay, whichever is higher. There is no change to the requirement for the active duty family member's cost-share to be applied to the institutional charges for inpatient services. If the contractor learns that the participating provider has billed a beneficiary for a greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement.

8. Reserved

9. Reserved

10. Reserved

11. Reserved

12. Reserved

D. Duplicate Payment Prevention

Each claim must be checked for duplicate billing to prevent erroneous expenditures. Duplicate detection requires both automated and manual procedures. Following are procedures for prevention of duplicate payments. If a contractor believes alternative procedures will meet the requirement it can request approval of such alternative procedures from TMA, at least thirty (30) days prior implementation. The TMA Claimcheck duplicate edits will be used to enhance existing requirements rather than replace them.

1. Automated Duplicate Checking - Individual Providers

Each line item on a claim must be checked for duplication against claims processed and claims in process for that beneficiary, as well as against other line items on the same claim. At a minimum, the following fields shall be compared:

a. Dates of Service (individual dates or inclusive dates)

b. Provider Number

c. Type of Service (see Section VI.D.5. below for categories)

d. Procedure Code

e. Place of Service (see Section VI.D.5. below for categories)

f. Submitted Charge

g. Exact Duplicate

Matches on all six (6) fields (exact date(s) of service, provider number, type of service, procedure code, place of service, submitted charge) with completed or in-process claims shall be denied without clerical intervention. If the exact duplication occurs within a claim, clerical intervention is required.

h. Potential Duplicate

Two steps are required for automated detection of potential duplicates:

(1) Step 1

(a) Match the **date of service** with:

1 Provider Number

2 Type of Service and Procedure Code

3 Type of Service alone

(b) Contractors shall establish an edit which will identify a delivery billed within eight (8) months of a prior delivery for the same beneficiary.

1 Option No. 1

The date of service (including overlap of inclusive dates) shall be first matched with the provider number. If there is a match on both items, the claim shall be pended for clerical review. The remaining claims shall be screened in the next sequence with the date of service, including overlap of inclusive dates, matched with the **type of service and procedure code**. If there is a match on these items, the claim shall be pended for clerical review.

2 Option No. 2

The date of service, including overlap of inclusive dates, shall be first matched with the provider number the same as in Option 1. Where there is a match, the claim shall be pended for clerical review. The remaining claims shall be screened further with the date of service, including overlap of inclusive dates, matched with the **type of service alone**. Again, if there is a match, the claim shall be pended for clerical review.

(2) Step 2

(a) Compare line items within the same claim. Identify line items as potential duplicates if:

1 Provider numbers agree

2 Dates of service overlap

3 Type of service is equal

4 Procedure codes are equal

(b) If provider numbers do not agree, dates of service that overlap shall be matched with type of service and procedure code. If these are equal, the line items shall be identified as potential duplicate services and the claim shall be pended for clerical review.

2. Automated Duplicate Checking - Institutional Providers

Prevention of duplicate payments for services billed by institutions requires a coarser screen and more manual review than professional claims due to the lack of detailed itemization. Contractors shall compare the date(s) of service on inpatient and outpatient institutional claims for a particular beneficiary with those on other institutional claims processed and in process for that beneficiary. When there is a match or overlap, contractors shall pend the current claim(s) for manual review.

3. Manual Duplicate Checking (Clerical Review)

All claims identified by the automated system as potential duplicates require clerical review. Some may require retrieval of the hard copy or microcopy of the suspected duplicate claim and copies of previously processed or other in-process claims. The clerical review shall be used to resolve issues of concurrent care and utilization of services, as well as the question of duplicate service(s). Contractors should determine the medical necessity of concurrent care and/or multiplicity of services. Overlapping dates of

service on consolidated drug claims would normally require retrieval of the individual claim to rule out duplication of drug charges.

4. Reserved

a. Reserved

b. Reserved

5. Place of Service/Type of Service Categories

Contractors must use Place of Service and Type of Service codes found in the Automated Data Processing and Reporting Manual for the following categories, as a minimum, for use in duplicate checking:

Place of Service	Type of Service
Inpatient Hospital	Medical Care
Outpatient Hospital	Surgery, including Fracture Care
Provider's Office	Consultations
Patient's Home	Diagnostic Laboratory
Day Care Facility	Diagnostic X-ray
Night Care Facility	Radiation Therapy
Nursing Home	Anesthesia
Skilled Nursing Facility	Assist at Surgery
Ambulance	Other Medical
Other Locations	Psychiatric Care
Independent Laboratory	Maternity
Other Medical/Surgical Facility	
Residential Treatment Center	
Specialized Treatment Facility	

6. Automated TRICARE Duplicate Claims System

The contractor is required to install and utilize the automated TRICARE Duplicate Claims System for the retrospective identification of duplicate payments. The automated TRICARE Duplicate Claims System identifies potential duplicate claims payments on the HCSR payment record database and displays them for contractor action. (See ADP Manual, *Chapter 11* for a description of the automated TRICARE Duplicate Claims System and the requirements for its operation.) The automated TRICARE Duplicate Claims System does not remove the obligation for prepayment prevention of duplicate payments by the contractor.

E. Health Care Service Record Detail Line Item - Combined Charges

Combining charges for the same procedures having the same billed charges under the contractor's "at-risk" operation, for health care service records, is optional with the contractor if the same action is taken with all. However, for example, if the claim itemizes services and charges for daily inpatient hospital visits from 03-25-99 to 04-15-99 and surgery was performed on 04-08-99, some of the visits may be denied as included in the surgical fee (post-op follow-up). The denied charges, if combined, would have to be detailed into a separate line item from those being allowed for payment. Similarly, the identical services provided between 03-25 and 03-31, inclusive, would be separately coded from those rendered in April. The option to combine like services shall be applied to those services rendered the same calendar month. Refer to the ADP Manual, Chapter 2.

F. Relationship Editing for Accuracy of Data Input

Each claim processed shall be edited for consistency of information in such a way that all payments and health care service record submittals will meet both accuracy and timeliness requirements. The ADP Manual contains information which may be used by contractors in meeting program requirements. These edits are intended for TMA use to validate the accuracy of submitted data, but are made available to contractors to assist in ensuring accuracy of health care service record submissions.

G. Payment to Provider or Beneficiary is 99 Cents or Less

1. Effective for all contracts awarded in FY94 and thereafter, summary voucher payments or individual claim payment checks for $.99 or less, shall be written by the contractor, but not mailed to the beneficiary or provider, using an appropriate EOB message. The checks shall be voided and processed as outlined in OPM Part One, Chapter 4, Section VI.A.

2. If the provider/beneficiary demands payment of $.99 or less, advise him/her that it is TRICARE policy not to issue checks for $.99 or less.

3. At the end of the year when the contractor issues the provider's Form 1099, the withheld amounts shall NOT be shown on the Form 1099.

H. Explanation of Benefits (EOB)

1. EOB Issuance Requirements

The contractor shall issue and mail an appropriate EOB to the beneficiary (parent/guardian for minors or incompetents) for each claim processed to a final determination. In those circumstances where the beneficiary has no "out of pocket" expenses, including deductibles or cost-shares, and there are no denied charges included on the claim for which he/she is, or may be, responsible, issuance of an EOB may be waived. (For the purpose of issuing EOBs, Prime beneficiary copayments are not considered out-of-pocket expenses.) When an EOB is required, it must be issued to the beneficiary regardless of whether or not the provider is a participating provider and whether or not an actual payment is involved; e.g., allowed amount is applied to the deductible or payment is $.99 or less and no check is mailed. The EOB shall be provided to the nonparticipating provider with

the amount allowed so that he/she can determine what amount may be billed to the beneficiary under the balance billing provision (115% of the TRICARE allowable charge). Only the charges of the nonparticipating provider would normally appear on the EOB; however, the nonparticipating provider should only be provided with information where there is a "need to know". This means that if other information appears on the EOB that does not pertain to the nonparticipating provider, the TRICARE contractor is to suppress printing or remove it before sending the EOB to the nonparticipating provider. The nonparticipating provider will receive only the EOB and the beneficiary will receive the TRICARE payment. Network providers will be paid according to the agreements and administrative procedures established with the contractor. Contractors shall also issue EOBs to participating providers or issue summary vouchers covering multiple claims and beneficiaries in lieu of issuing multiple EOBs. Sufficient information must be included on the vouchers to identify each beneficiary and explain the payment for each line item on each claim. Use of a summary voucher does not change the requirement for a separate EOB to be sent to each beneficiary for each claim. Each contractor shall include adequate identification of the fiscal year involved applicable to the various charges listed on the EOB to help keep the deductible information clear to the beneficiary. (See the ADP Manual, Chapter 2, for HCSR requirements.) If the claim is from a state Medicaid agency, the copy usually sent to a participating provider will be sent to the state agency. The contractor will include the same information on the copy sent to the state as it normally sends to participating providers. If the state has a need which cannot be accommodated except at extra expense, the contractor may negotiate with the state, if it chooses, and if the state is willing to pay for the accommodation.

2. EOB Issuance Exceptions

a. Reserved

(1) TRICARE Prime

The issuance of an EOB is optional only in TRICARE Prime when the beneficiary is not liable for payment of any out-of-pocket expense. (For the purpose of issuing EOBs, Prime beneficiary copayments are **not** considered out-of-pocket expenses.) At all other times it is required. In case of doubt, the contractor shall obtain approval from the contracting officer for waiver.

(2) Abortion, AIDS, Alcoholism, Drug Abuse or Venereal Disease

(a) Contractors shall not issue EOBs to beneficiaries (parents/guardians of minors or incompetents) when claims involve services related to the following diagnostic codes:

	ICD-9-CM
Abortion	634-639.9[2]; 779.6
AIDS	079.53; 042

[1] Including 4th digits
[2] Including 4th and 5th digits
[3] Including 5th digits

	ICD-9-CM
Alcoholism	291-291.9[2]; 303-303.9[2]; 305[3]
Drug Abuse	292-292.9[2]; 304-304.9[2]; 305.2-305.9[3]
Venereal Disease	090-099.9[2]; 294.1

[1] Including 4th digits
[2] Including 4th and 5th digits
[3] Including 5th digits

(b) EOBs must be issued to participating providers, except as noted above. The contractor shall provide an EOB to a beneficiary upon request. When a request is made for a normally suppressed EOB, the copy provided may be a facsimile or a hand-produced copy. It must, however, include the required data and be certified by the contractor.

(c) When a service(s) is denied due to an abortion, a letter of explanation shall be sent, but only when the denial is questioned by the beneficiary. Figure 2-1-A-12 provides suggested wording for abortion claims that are denied. **The explanation shall be provided only to the beneficiary and participating provider.** The special denial letter shall be sent in an envelope marked "personal". **It is EMPHASIZED that using an Explanation of Benefits is NOT acceptable for denial of abortion services.** Only an approved letter may be used.

(3) Nonparticipating Provider

When a claim for service from a nonparticipating provider is allowed at the billed charge, the EOB, at the contractor's discretion, need not be sent to the nonparticipating provider since the balance billing provision does not apply.

b. Procedures for Informing the Beneficiary of Claim Action

The handling of claims for the diagnostic or procedural codes in Section VI.H.2.a.(2), above, requires sensitivity to the beneficiary's right to privacy. Because of the need for contractors to apply reasonable judgment on a case-by-case basis, TMA has not prescribed specific procedures except in the case of abortion claims. **A special denial or referral letter is to be used for services or supplies related to an abortion**. (Refer to Section IV.J.5., of this chapter for procedures on abortion claims.) For claims involving services and supplies for the other diagnoses, a phone call to the beneficiary may serve to obtain information on how the beneficiary wishes to have the EOB handled in some instances. In other cases, a request that the provider serve as an intermediary, or a personal letter to the beneficiary, using a plain envelope, may be appropriate. Whatever approach is chosen, contractors must observe the intent, as well as the letter, of the Privacy Act.

3. EOB Format

The form design of the EOB is not specifically prescribed. Contractors shall design the form to fit their individual equipment and system needs. Prior to printing, however, the form must be approved by TMA. The following are required contents of the EOB:

a. Contractor Identification

The name or logo of the contractor and the region specific TRICARE logo must be present on the front of the EOB, even though it appears on a detachable check.

b. Form Title

"EXPLANATION OF BENEFITS" shall appear in a prominent place near the top of the EOB form in boldfaced type at least as large as the organization logo or name of the contractor, and in a type size and style which will make it clearly visible.

c. Form Subheadings

The subheadings "THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR TRICARE CLAIM," and "KEEP THIS NOTICE FOR YOUR RECORDS," shall also appear near the top of the form in a **boldfaced** type slightly smaller than the title of the form.

d. Data Required on Front of EOB Form

Provisions shall be made on the front of the form for inclusion of the following elements:

(1) The Internal Control Number (ICN)

(2) The Date the EOB is prepared (Run Date)

(3) Check Number

(4) The contractor's address and telephone number. The contractor's telephone number for the state or locality of the beneficiary or provider may be computer-printed.

(5) Sponsor's Social Security Number

(6) Beneficiary's Name and Sponsor's Name

The sponsor's last name and first name or initial, and the beneficiary/patient's **full first name** must be shown on the EOB.

(7) Payee's Name and Address

This space is used when payment is made to someone other than the beneficiary (parent/legal guardian of minor or incompetent); e.g., the provider, administrator of an estate or a Medicaid agency. The full name of the payee must be used, if available.

(8) Procedure Code and a short description of services. (Not required for claims paid under the TRICARE/CHAMPUS DRG-based payment system.)

(9) Date of Service or From - To Dates for combined services.

(10) Number of Services

Enter number of services provided when services are combined. (Not required for claims paid under the TRICARE/CHAMPUS DRG-based payment system.)

(11) Name of Provider of Service

Since prescription drugs are paid as billed, you may use "your pharmacy" for nonassigned prescription drug claims instead of developing for the name and address of each provider. In addition, "Your Provider" or "Your Supplier" may be used when **all** of the following conditions are met:

(a) A valid name/number cannot be assigned from the information at hand.

(b) The claim is totally denied

(c) The claim is non assigned

(12) Amount Billed

Enter amount billed by provider

(13) Amount Allowed

Enter amount allowed by TRICARE. For claims paid under the TRICARE/CHAMPUS DRG-based payment system, this will be a total amount for the entire claim and need not relate to individual line items. If, under a program approved by the Director, TMA, a provider has agreed to discount his or her normal billed charges below the profiled amounts, the amount allowed may not be more than the negotiated or discounted charges.

(14) Payment Reduction Amount

If applicable, enter the amount of the payment reduction as provided in the Policy Manual, Chapter 13, Section 24.1.

(15) Reduction Days

If applicable enter the number of days subject to the payment reduction as provided in the Policy Manual, Chapter 13, Section 24.1.

(16) Amount Paid by Beneficiary to Provider

Enter the amount, if any, paid by beneficiary to provider on participating claims.

(17) Amount Allowed by Other Insurance

If applicable enter the amount allowed by the other health insurance (OHI). See the Policy Manual, Chapter 13, Section 24.1.

(18) Paid by other Insurance

Enter amount paid by other insurance (if applicable)

(19) Total Payment

Enter total amount paid on the claim

(20) Amount Accrued Toward Deductible Amount

Enter the amount of the individual deductible which has been satisfied for the fiscal year, including the amount applied on the current claim, and the amount of the family deductible which has been satisfied for the fiscal year.

(21) Amount Deductible this Claim

Enter the amount of the deductible satisfied by the current claim.

(22) Remarks/Action Section

(a) Enter reasons for disallowance or reduction in this space. (If codes are used, the corresponding messages must appear on the EOB.)

(b) When appropriate, enter the following: "Our records show XX days of inpatient mental health services have been used in calendar year XXXX." (If a contractor finds it more cost effective to send a separate letter or notice showing inpatient mental health days used, a copy of the proposed letter shall be sent to the Operations Directorate, TMA, for review and approval.)

(c) The contractor shall develop and maintain a list of EOB messages that explain what adjudication occurred on each claim, in language that can be understood by the average person.

e. Information Required on Reverse of EOB Form

All of the following information must be on the reverse of the EOB.

(1) Time Limit for Filing Claims

(a) Reserved

(b) For services provided on or after January 1, 1993, all claims submitted under TRICARE must be filed no later than one year after the date the service or supply was provided or one year from the date of discharge from an inpatient admission for facility charges only.

EXAMPLE:

For Service or Discharge	Received by the Contractor
March 1, 1999	No later than March 1, 2000
December 31, 1999	No later than December 31, 2000

(c) If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your health benefits advisor for assistance. In limited circumstances, exceptions may be made.

(2) Sponsor, Patient, or Family Member Not Enrolled or not Eligible on DEERS

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or family member is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card (or parent's ID for

family member under ten (10) years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's ID card. If the sponsor is deceased, report to any service personnel office to get enrolled or call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602).

(3) Identification Card (ID) or Eligibility Expired on DEERS

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to your parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card. In an emergency, call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602) for assistance.

NOTE:

Contractors may shorten messages (2) and (3) by eliminating the 800 numbers which do not apply to their region(s).

(4) Right to Appeal

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your signed written request must state the specific matter with which you disagree and **MUST** be sent to the following address no later than ninety (90) days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

(Contractor's Address)

(5) TRICARE Outpatient Deductible

Effective for care provided on or after April 1, 1991, a TRICARE beneficiary is responsible for the payment of the first one hundred fifty dollars ($150.00) of the TRICARE-determined allowable costs or charges on processed claims for covered outpatient services or supplies provided in any one fiscal year. When outpatient services are provided to more than one beneficiary member of a family, the aggregate outpatient deductible amount paid by two or more beneficiary members of the family who submit claims shall not exceed three hundred dollars ($300.00) during any fiscal year. Deductible amounts remain unchanged for family members of active duty E-4s and below; $50.00 per beneficiary or $100.00 for two or more family members. Sponsors/beneficiaries are required to ensure that the proper pay grade/rank is on the DEERS records.

(6) If Payment not Based on the Full Amount Billed

The amount TRICARE may allow is limited by law to the lowest of:

(a) The CHAMPUS Maximum Allowable charge; which for most procedures is equal to the Medicare fee schedule amount; OR

(b) The amount the provider actually charges for the service or supply (to include a discounted charge that a participating provider has agreed to accept under a special program).

NOTE:

Under some circumstances, the contractor responsible for payment for care in the region will negotiate rates with preferred providers which will be different than the CHAMPUS Maximum Allowable Charge or the provider's usual charge. In such a case, the agreement made by the contracted provider, establishing allowable charge levels will prevail. In this instance, the provider will be participating and payment will be made directly to the provider who will be limited to the agreed charge level in full payment.

(7) Important Notices

(a) Always Give Your Social Security Number When Writing About Your Claim.

NOTE:

If inquiring about this claim, please provide the Internal Control Number located on the front of this form.

(b) You Can Use This Explanation Of Benefits:

1 As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.

2 As a record of bills paid or denied. (If you submitted other medical expenses not shown on this form, you will receive a separate notice.)

3 To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

(c) Claims payments are subject to the provision that the beneficiary cost-share is collected by the provider, whenever appropriate. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

(d) If you need more information:

1 Check your TRICARE Standard Handbook.

2 See the health benefits advisor or health care finder at the nearest Military Treatment Facility (MTF) *or TRICARE Service Center (TSC)*.

3 Contact us at the address shown on the front of this form.

(e) Please review the services shown on the front side of the Explanation of Benefits (EOB). If you find that the payment consideration has been made for any services that you did not receive or that services were charged by a healthcare

professional you did not see, please call the "800" telephone number on the front side of the EOB form.

4. Summary Voucher Information

The summary voucher must contain the following:

a. Form Title: "TRICARE Summary Payment Voucher"

b. Contractor's Name, Address, and Telephone Number.

c. Date of Notice.

d. Name, Complete Address including zip code, and identification number of payee.

e. Name of Beneficiary

f. Sponsor's Social Security number

g. Internal Control Number

h. Date of Service

i. Procedure Code and Brief Description of Service

j. Number of Services

k. Amount Billed

l. Amount Allowed

m. Denial code or reason for the denial. If codes are used, print the corresponding messages on the back of the form.

n. Deductible applied (the amount applied to the deductible).

o. Summary total to include billed charges, allowed charges, and amount to deductible or cost-share.

p. Total TRICARE payment made by this voucher to the payee.

q. Remarks (Enter longer explanation messages in this space.)

r. Other statements. (See Section VI.H.3.e.). The statements are not required on summary vouchers if a copy of the EOB is included with the voucher.

s. DRG Number

t. Amount paid by other health insurance

5. Explanations of Differences between Billed and Allowed Amounts

Each disallowance or reduction must be clearly explained on EOB's and summary vouchers using codes referring to statements on the reverse or using printed

messages on the face. The messages used on the EOB must be compatible with those on the summary voucher.

6. Undeliverable/Returned Mail

a. Time Requirements for Research/Remailing

Contractors must accomplish all research for the correct address/addressee and remail within five (5) work days of the receipt of the returned mail, if necessary.

b. Procedures for Handling Returned Mail

When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the contractor shall verify the accuracy of the address on all returned mail and remail if a better address is located. Do not remail if the previous address is the best address available. The EOB or correspondence shall be maintained on-line or in hardcopy for audit purposes, and the check shall be voided.

I. Claims Splitting

As a general rule under HCSRs, claims should not be split (unless otherwise indicated) but should be reported using the same ICN with a different suffix. Single claims may be split in accordance with the following rules:

HCSRs	1. A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under HCSRs for different beneficiaries.
HCSRs	2. A claim for the lease/purchase of durable medical equipment that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under HCSRs.
HCSRs	3. A claim that contains services, supplies or equipment covering more than one contractors jurisdiction shall be split. The claim and attached documentation shall be duplicated in full, and identification shall be provided on each document as "processed" by the contractor and then mailed to the other appropriate contractor having jurisdiction. The contractor splitting the claim counts the remaining material as a single claim, and the contractor receiving the split material for its jurisdiction, counts it as a single claim, unless the split material meets one or more of the other criteria for an authorized split.
HCSRs	4. A claim that contains more than $999,999.99 may be split. This includes DRG claims with submitted charges exceeding $999,999.99.
HCSRs	5. An inpatient maternity claim which is subject to the TRICARE/CHAMPUS DRG-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the Policy Manual, Chapter 11, Section 5.1.

HCSRs	6. A claim with procedures which require an NAS as well as procedures which do not require an NAS shall be split, because there will be both institutional and noninstitutional services.
HCSRs	7. A claim submitted with both inpatient and outpatient services requiring a Nonavailability Statements may be split, because there would be both institutional and noninstitutional services.
HCSRs	8. Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) shall be reported on a non-institutional format. See the Policy Manual, Chapter 13, Section 22.1D.
HCSRs	9. A claim submitted on behalf of a nonparticipating provider with dates of service on and after November 1, 1993, shall be multi-suffixed to account for the balance billing limitation based upon the dates of service effective with processed to completion date on or after November 1, 1993.
HCSRs	10. A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for (1) charges for services which are included in the prospective group payment rate, (2) charges for services which are not included in the prospective group payment rate and are separately allowable, and (3) physician's fees which are allowable in addition to the facility charges. (See the Policy Manual, Chapter 13, Section 9.1.)

J. Pharmacy Data Transaction Services (PDTS)

The contractor (and its subcontractors, as appropriate) shall participate in the reporting and exchange of pharmacy services data in support of DoD's Pharmacy Data Transaction Services (PDTS). The PDTS is intended to serve as an integrated record of all pharmacy services received by DoD beneficiaries, regardless of the source of those services.

1. Technical specifications, communications protocols and business rules for the data exchange with the contractor are contained in the Interface Control Document (ICD) which can be accessed on the internet (http://www.*milmed*.*net*) via the Livelink® PDTS user name and password which has been established for each Managed Care Support *c*ontractor and claims processing subcontractor.

2. Edits, alerts and rejections returned to the Managed Care Support contractor by the PDTS contractor, secondary to the contractor's internal Prospective Drug Utilization Review (ProDUR) system routines, shall be treated as informational only. Managed Care Support contractors shall continue to follow their own currently established policies and procedures for pharmacy services review and adjudication.

K. Reserved

L. Former Spouses with Pre-Existing Conditions

The former spouse will be coded as ineligible on DEERS. A Memorandum of Authorization issued by the military service must be attached to the claim to provide the period of eligibility and identify the specific pre-existing condition for which TRICARE benefits are authorized. If the Memorandum of Authorization is attached, the contractors shall override the DEERS eligibility response and the NAS requirements and process the claim. If the Memorandum of Authorization is not attached, the claim shall be denied as eligibility expired on DEERS.

M. Reserved

N. Procedures For Contractor Coordination On Out-of-Jurisdiction Providers

Contractors subject to the requirements of the Automated Data Processing and Reporting Manual who are responsible for processing claims for care provided outside of their provider certification jurisdiction shall first search available provider files, including the TMA-supplied copy of the TRICARE centralized provider file (to be provided at least weekly), to determine provider certification status, obtain related provider information, and determine if the certifying contractor has submitted a Health Care Provider Record (HCPR) for the out-of-area provider.

1. File Search Unsuccessful

If the file search is unsuccessful, the following procedures apply:

a. The servicing (claims processing) contractor shall request provider information from the certifying contractor.

b. Each contractor shall designate a point of contact as specified in this chapter at Section II.A. who shall be responsible for initiating actions related to such requests and ensuring these actions are timely and well documented.

c. The certifying contractor shall respond within five (5) workdays of the request with either a.) complete provider information for the servicing contractor to process the claim and submit a Health Care Service Record (HCSR) in situations when a HCPR has already been accepted by TMA or b.) the information that a HCPR for the provider in question has not been submitted to or accepted by TMA and one of the following situations exist:

(1) The certifying contractor has sufficient documentation (including the provider's TIN) to complete the certification process and determine the provider's TRICARE status; or

(2) The certifying contractor does not have sufficient documentation to determine the provider's status and complete the certification process; or

(3) The certifying contractor has sufficient information to determine that the provider does not meet TRICARE certification requirements without going through the certification process; or

(4) Situations 1., 2., or 3. above apply, but the certifying contractor is not subject to the requirements of the Automated Data Processing and Reporting Manual.

2. HCPR Submission

Since the servicing contractor will be unable to complete HCSR processing until a HCPR is accepted by TMA, a coordinated effort is required between the servicing contractor and the certifying contractor in the above situations. The certifying contractor is responsible for ensuring the HCPR is accepted by TMA before supplying the provider information indicated at Section VI.C.6. Contractors should not delay submitting HCPRs for providers who have requested certification and such certification has been granted or denied, solely because the provider has not yet submitted a TRICARE claim. When the HCPR is accepted, the certifying contractor shall notify the servicing contractor of this within two (2) workdays of its acceptance and supply the provider information. Following are procedures and time frames to facilitate this coordination.

a. If the certifying contractor has completed its provider certification process but has yet to submit the HCPR (or clear the HCPR through the TMA edits), the certifying contractor shall submit (or resubmit) the HCPR within one (1) workday of contact by the servicing contractor and notify the servicing contractor within two (2) calendar weeks following the initial contact, of the HCPR submission action taken and whether the HCPR has been accepted.

b. If the certifying contractor does not have sufficient documentation to complete the certification process and submit a HCPR, the certifying contractor shall initiate (or follow up on) the certification process within two (2) workdays of the initial contact by the servicing contractor. If it is necessary to obtain documentation from the provider, the certifying contractor shall allow no longer than a two (2) calendar week suspense from the date of its request.

(1) Upon determination that the documentation is complete, the certifying contractor shall complete the certification process, submit the HCPR, and notify the servicing contractor within one (1) additional calendar week following completion of the certification process (i.e., within three (3) weeks of the initial contact by the servicing contractor). The certifying contractor shall also notify the provider of the certification determination and of procedures for contacting the certifying contractor in the future regarding provider-related (nonclaim) matters (e.g., address changes).

(2) If the certifying contractor is unable to complete the certification process within three (3) calendar weeks following the initial contact, it shall submit the HCPR and notify the servicing contractor within four (4) calendar weeks following the initial contact.

(a) If the certifying contractor has substantial evidence (e.g., state licensure listing) that the provider meets TRICARE certification requirements, it shall consider the provider certified and so inform the servicing contractor one (1) work day after acceptance.

(b) If the certifying contractor does not have substantial evidence that the provider meets TRICARE certification requirements, it shall

not consider the provider to be certified. The servicing contractor shall deny the claim using an appropriate EOB message.

(c) In either of the above cases, if the certifying contractor does not have the provider's TIN, it shall submit the HCPR with a contractor Assigned Provider Number (APN) as described in the ADP Manual, Chapter 2, Section 10, Provider Taxpayer Number, and provide this number to the servicing contractor. The servicing contractor shall issue payment only to the beneficiary in this case if the claim is otherwise payable (even in the unlikely event that the provider is participating).

(d) If, at the time of the servicing contractor's initial contact, the certifying contractor is able to determine that the provider does not meet the TRICARE certification requirements without going through the certification process, it shall submit the HCPR and notify the servicing contractor within two (2) calendar weeks of the initial contact. If the provider's TIN is not known, the certifying contractor shall assign an APN. The servicing contractor shall deny the claim using an appropriate EOB message.

(e) If the certifying contractor is not subject to the requirements of the Automated Data Processing and Reporting Manual, the servicing contractor will assign the provider sub-ID and create the HCPR. The certifying contractor shall provide the servicing contractor with the minimum provider information listed in Section VI.N.2.d. below, within two (2) workdays of the initial contact by the servicing contractor if the certification process has been completed or if a determination can be made that the provider does not meet the certification requirements without going through the process. If it has not been completed, the servicing contractor shall be so notified within two (2) workdays of the initial contact and the procedures and time frames in Section VI.C.2. above shall be followed.

c. The servicing contractor shall notify the TMA Contracting Officer's Representative if the certifying contractor does not provide the required provider information and notification of the HCPR's acceptance by TMA within thirty-five (35) calendar days from the time of the initial contact.

d. The minimum provider data to be provided by the certifying contractor is the provider's certification status including the reason a provider is not certified if such is the case, any special prepayment review status, and the following HCPR data:

(1) Provider Taxpayer Number or Assigned Provider Number

(2) Provider Sub-identifier (may need to be assigned by the servicing if the certifying contractor is not on HCSRs)

(3) Provider Contract Affiliation Code

(4) Provider street address

(5) Provider "pay to" address

(6) Provider State or Country

(7) Provider Zip Code

(8) Provider Specialty (noninstitutional providers)

(9) Partnership data (Partnership indicator, discount percentage, effective and ending dates)

(10) Type of Institution (institutional providers)

(11) Type of reimbursement applicable (DRG, MHPD, etc.)

(12) Per diem reimbursement amount, if applicable

(13) IDME factor (where applicable)

(14) Provider Acceptance Date

(15) Provider Termination Date

(16) Record Effective Date

e. The certifying contractor shall provide additional data upon request of the servicing contractor or TMA to meet internal processing, prepayment review, or file requirements or, to create a HCPR when the certifying contractor is not under the requirements of the Automated Data Processing and Reporting Manual. The certifying contractor shall also provide the pricing information and any special provider reimbursement arrangements for the servicing contractor to accurately determine the allowable amount for the provider's services if the provider is TRICARE certified.

f. Maintenance of HCPR with an Assigned Provider Number (APN)

g. In all cases when an APN is assigned, the certifying contractor shall attempt to obtain the provider's actual TIN. Within ten (10) workdays of receipt of the provider's TIN, the certifying contractor who is under the requirements of the Automated Data Processing and Reporting Manual shall inactivate the APN HCPR and add the HCPR with the provider's TIN regardless of whether the provider meets TRICARE certification requirements.

h. Provider Correspondence

i. Any provider correspondence which the servicing contractor forwards for the certifying contractor’s action or information shall be sent directly to the certifying contractor’s point of contact to avoid misrouting.

j. Within one (1) week of receipt, the servicing contractor shall forward for the certifying contractor's action any correspondence or other documentation received which indicates the need to perform a provider file transaction. This includes, but is not limited to, such transactions as address changes, adding or deleting members of clinics or group practices, or changing a provider's TIN.

k. Provider Certification Appeals

l. Requests for reconsideration of an contractor's adverse determination of a provider's TRICARE certification status are processed by the certifying contractor. Any such requests received by the servicing contractor are to be forwarded to the certifying contractor within five (5) workdays of receipt and the appealing party notified of this action and the reason for the transfer. The certifying contractor shall follow standard appeal procedures including aging the appeal from the date of receipt by the certifying

contractor, except that, if the reconsideration decision is favorable, the provider shall be notified to resubmit any claims denied for lack of TRICARE certification to the servicing contractor with a copy of the reconsideration response. In this case, the certifying contractor shall ensure a HCPR for this provider is accepted by TMA within one (1) calendar week from the date of the appeal decision.

m. The servicing contractor shall forward to the certifying contractor within five (5) workdays of receipt any provider requests for review of claims denied because the certifying contractor was unable to complete the certification process. The servicing contractor shall notify the provider of the transfer with an explanation of the requirement to complete the certification process with the certifying contractor. Upon receipt of the provider's request, the certifying contractor shall follow its regular TRICARE provider certification procedures. In this case, no basis for an appeal exists. If the provider is determined to meet the certification requirements, the special provider notification and HCPR submittal requirements apply.